National Senior Citizens Law Center

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Health Care Reform and Low-Income Older Adults: An Overview

With the enactment of the *Patient Protection and Affordable Care Act* (PPACA) on March 21, 2010, health care reform finally became a reality. This historic legislation will impact virtually every facet of the nation's healthcare system and provides numerous opportunities for millions of individuals to receive services to which they currently lack access.

This issue brief provides a summary of provisions of the new law that impact low-income older adults. The brief is divided into four sections:

- Long-Term Services and Supports, p. 1
- Dual Eligibles (persons eligible for both Medicare and Medicaid), p. 2
- Long-Term Care Facilities, p. 4
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More detailed analysis of each provision mentioned here is available at www.nsclc.org or via the links included in this document. NSCLC looks forward to working with its partners to ensure that these provisions are implemented to the benefit of vulnerable older adults.

LONG-TERM SERVICES AND SUPPORTS

Below is a summary of the PPACA provisions that impact Medicaid's coverage of long-term services and supports (LTSS). For more details on these provisions, see "The Medicaid Long-Term Services and Supports Provisions in the Health Care Reform Law" at www.nsclc.org/areas/medicaid/health-reform-ltss.

State Balancing Incentive Program. Offers financial incentives to states that are spending less than 50% of their Medicaid LTSS dollars on community-based services to shift more Medicaid spending toward the community.

Community-Based Attendant Service Option. Creates a new Medicaid benefit for individuals with an institutional level of need who want to remain in their homes or other community-based setting. States choosing to make the service part of their state plan will receive a six percentage point increase in their federal Medicaid reimbursement rate for the services delivered through the benefit. States may offer coverage for the benefit beginning October 2011.

Improvements to the HCBS State Plan Option. The PPACA enhances the Medicaid HCBS state plan benefit by expanding the services that can be available in the benefit and eliminating

state discretion to, among other things, cap the number of individuals receiving coverage for the benefit. The law also authorizes states to make HCBS state plan benefit recipients a distinct categorical eligibility group.

Extension of the Money Follows the Person Program. Appropriations for the Money Follows the Person (MFP) program, under which states receive additional federal assistance to help Medicaid-enrolled nursing facility residents transition to home or community-based settings, are authorized through the end of the 2016 fiscal year. The PPACA also reduces MFP's minimum institutional residency requirement from six months to 90 days and prohibits states from imposing a longer one.

Expansion of Medicaid's Spousal Impoverishment Protections. Requires states, beginning in 2014, to extend Medicaid's spousal impoverishment protections to the spouses of all Medicaid enrollees receiving HCBS coverage through waivers or certain state plan benefits. The mandate will be set for five years, ending in 2019.

Additional Support for Aging and Disability Resource Centers. The PPACA authorizes $10 million in additional support for the Aging and Disability Resource programs from 2010 through 2014.

DUAL ELIGIBLES: MEDICAID, MEDICARE PART D AND MEDICARE ADVANTAGE

Below is a summary of the PPACA provisions that impact dual eligibles including changes to Medicaid, Medicare Part D and Medicare Advantage. For more details on these provisions see, "Health Care Reform, Dual Eligibles and Coverage Expansions" at www.nsclc.org/areas/medicare-part-d/health-reform-duals.

Establishing an "Office of Duals." CMS must establish a Federal Coordinated Health Care Office that is tasked with leading efforts to improve integration of Medicare and Medicaid benefits for dual eligibles. In addition, the law authorizes a number of pilot and demonstration projects involving care coordination for dual eligibles.

"Medical Assistance" as Payment. In providing "medical assistance," states must operate their programs in a manner that ensures that beneficiaries will actually receive promised services, not simply be reimbursed if they manage to acquire those services on their own.

Eliminating Part D Co-Payments for HCBS recipients. Part D co-payments are eliminated for individuals receiving Medicaid funded home and community based services. Effective no earlier than January 1, 2012.

Stabilizing Part D Plan Options for LIS Recipients. Two technical, but important provisions are expected to increase the number of zero premium plans Low-Income Subsidy (LIS) recipients can enroll in. Effective plan year 2011.

Extending Widow(er)s' LIS Eligibility. The LIS eligibility of an individual whose spouse dies during a period of LIS eligibility will be extended by one year. Effective January 1, 2011.

Closing the 'Donut Hole.' The Part D donut hole will be phased out by 2020. Individuals who reach the donut hole in 2010 will receive a $250 rebate to help cover drug costs.

Extending Special Needs Plans. Authorization for a type of Medicare Advantage plans known as Special Needs Plans (SNPs) is extended until 2014.

New Annual Coordinated Election Period (AEP) for Part D and Medicare Advantage. Starting in the Fall of 2011, the AEP for Part D and Medicare Advantage will begin on October 15 and end December 7. Beginning in January 2011 there will also be a 45 day period at the start of each year during which individuals can disenroll from a Medicare Advantage plan and return to fee-for-service Medicare.

Complaint Process. The new law requires CMS to develop and maintain a complaint system for tracking and responding to complaints against Part D and Medicare Advantage plans. There is no timeline in the statute for this action.

Including ADAP and IHS Costs in the TrOOP Calculation. Effective in the 2011 plan year, costs incurred by the AIDS Drug Assistance Program (ADAP) and the Indian Health Service (IHS) will count towards the true out-of-pocket costs (TrOOP) incurred by Part D enrollees.

Racial, Ethnic and Language Data Collection. CMS must collect race, ethnicity and language data for Medicare beneficiaries.

Improved reassignment notices. Beginning no later than January 1, 2011, notices CMS sends to LIS recipients who are part of the annual reassignment process will need to include information about formulary differences between the new and old plan and a description of beneficiary rights to request a coverage determination and file an appeal to get access to their drugs.

Protected Classes of Drugs. CMS is provided the explicit authority to create protected categories and classes of drugs that must be covered by all Part D plans. Six protected classes already exist in the Part D program and the statute requires them to remain in place at least until CMS establishes criteria for editing or expanding the list.

Higher premiums for higher-income beneficiaries. Beginning in January 2011, higher income enrollees will be required to pay a higher portion of their Part D plan premiums. Low and middle income beneficiaries will not be affected.

Limiting Subsidies to Medicare Advantage plans. The rates paid to Medicare Advantage plans will be decreased.

Funding for SHIPs and AAAs. As with the ADRCs mentioned above, funding for State Health Insurance Counseling and Assistance Programs and Area Agencies on Aging will be extended and increased.

LONG-TERM CARE FACILITIES

Below is a summary of the PPACA provisions that relate to long-term care facilities. For more details on these provisions see, "Health Care Reform and Long-Term Care Facilities" at www.nsclc.org/areas/long-term-care/Nursing-Facilities/health-reform-ltc-facilities.

Information Disclosure and Quality of Care

Disclosure. Nursing facilities must disclose extensive information regarding owners and managers, to make facility control more transparent.

Compliance. Nursing facilities must institute programs to prevent violations and promote quality of care.

Quality Assurance. CMS must establish a quality assurance and performance improvement program for nursing facilities.

Standardized Complaint Form. CMS must develop a standardized complaint form for use by consumers in filing a complaint against a nursing facility to a state survey agency or ombudsman program.

Complaint Resolution. Each state must develop a complaint resolution process to assure that a facility does not retaliate against a resident's family members and friends.

Nursing Home Compare Website. Additional specified information must be posted on CMS's Nursing Home Compare website. Also, CMS must establish a process to review and improve the accuracy and clarity of information on Nursing Home Compare. The GAO must review the Five-Star Quality Rating System used on Nursing Home Compare.

State Websites. Each state is required to develop and maintain a consumer-oriented website providing useful information regarding each of the state's nursing facilities.

Special Focus Facilities. CMS is directed to develop a special focus facility program for enforcement of the nursing facility law against facilities that repeatedly have been out of compliance.

Availability of Inspection Reports. A nursing facility must have inspection reports from the previous three years available for review upon request.

Reporting of Nursing Facility Expenditures. Nursing facilities must separately report expenditures for wages and benefits for direct care staff, breaking out registered nurses, licensed nurses, nurse aides, and other medical and therapy staff members.

Staffing Data. Nursing facilities are required to submit their direct-care staffing levels electronically to CMS, with the data to be based on the facility's payroll and other auditable data.

Enforcement

Civil Money Penalties. CMS is authorized to reduce a money penalty against a nursing facility by up to 50 percent if the facility self-reports the violation and then corrects the deficiency within ten days of the penalty's imposition. For all civil money penalties, a facility will be able to participate in an independent dispute resolution process. CMS will have authority to require that money penalties be placed into an escrow account as they accrue, to be retained pending the resolution of any appeals. Some portion of collected penalty amounts may be used to support activities that benefit residents.

Nursing Facility Chains. CMS and the HHS Inspector General must conduct a demonstration project for an independent monitor program overseeing nursing facility chains. The demonstration project will include nine chains from among chains that apply to be included.

Nursing Facility Closures. A facility must provide written notice of the facility's closure at least 60 days before a scheduled voluntary closure.

Demonstration Projects on Culture Change and Information Technology. CMS must conduct demonstration projects on the development of best practices in culture change and in the use of information technology to improve resident care.

Surveyor Training. CMS must establish a National Training Institute for federal and state surveyors, to provide and improve training of surveyors with respect to investigating allegations of abuse, neglect, and misappropriation.

Complaint Investigation by Survey Agencies. CMS must make grants to state survey agencies to develop complaint investigation systems that prioritize complaints promptly, respond effectively, and optimize collaboration.

Long-Term Care Ombudsman Program. CMS must make grants to eligible entities to improve the capacity of state long-term care ombudsman programs, and conduct pilot programs within ombudsman programs.

Reporting of Crimes Occurring in Long-Term Care Facilities. Reporting of crimes is mandated in any long-term care facility that annually receives at least $10,000 in federal funding.

Staff Employment and Training

Dementia and Abuse Prevention Training. Required training in nursing facilities must include training in dementia care and abuse prevention.

Nationwide Program of Background Checks. CMS must establish a program to develop a process for nationwide background checks for direct-care employees.

National Nurse Aide Registry. CMS must conduct a study on establishing a national nurse aide registry.

Incentives for Employment in Long-Term Care Direct Services. CMS must provide incentives to support direct-care workers in long-term care. One goal is to create career ladders for direct-care employees.

COVERAGE EXPANSION AND INSURANCE MARKET REFORMS

Below is a summary of the PPACA provisions that impact low-income older adults who do not currently have health insurance coverage. For more details on these provisions see, "Health Care Reform, Dual Eligibles and Coverage Expansion" at www.nsclc.org/areas/medicare-part-d/health-reform-duals.

Expanding coverage to adults under 65. Medicaid is expanded to all adults under age 65 who have income under 133% of the Federal Poverty Level. Individuals with incomes above that amount will receive subsidies to purchase coverage in newly created exchanges. Effective January 1, 2014.

Insurance market reforms. Several insurance market reforms (for example, insurance companies will no longer be permitted to deny coverage based on pre-existing conditions, age rating will be limited and more) will make it easier for low-income older adults age 55-65 to afford and retain insurance.

Individual Mandate. In order to make the coverage expansion and insurance reforms possible, most individuals are required to have health insurance. NSCLC prepared, in December, an analysis of the constitutionality of the mandate, finding that it is clearly constitutional. To read the analysis visit, www.nsclc.org/areas/federal-rights/mandatory-health-insurance-is-it-constitutional/at_download/attachment.